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Midwifery and research

Comparable skills in listening and the use of language

Talking to women, and listening to them, is more valuable than bombarding them with questionnaires

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THE IMPORTANCE OF RESEARCH in midwifery is widely recognised with the move towards a profession that is evidence based. (Sandall, 1998). The foundations for policies, procedures and guidelines have mainly arisen from quantitative research, especially in the form of randomised controlled trials (RCTs) (NHS, 1996). The NHS Executive in 1996 stated that only recommendations based on RCTs should be used in contract setting (NHS, 1996).

With these recommendations there is a risk of elevating the importance of quantitative research to the detriment of qualitative research. It is important to recognise that practice can be enlightened by giving equal recognition to qualitative research methods.

Communication is an area that is amenable to qualitative research methodology and is an area that has been increasingly highlighted in *Changing Childbirth* (DoH, 1993), *Making a Difference* (DoH, 1999) and *The NHS Plan* (DoH, 2000) as an important aspect of midwifery care. This reinforces the significance of the midwife-mother relationship as fundamental to midwifery practice where the midwife constantly works within a cycle of interactions with women and their families, doctors, colleagues and researchers. This paper will therefore focus on communications within midwifery and on the qualitative aspects of research that can assist, build on and develop good communication skills as a necessary part of midwifery care.

The art of communication

The art of communication is based on a reciprocal process of sharing information and knowledge between two people (Kirkham, 2000) and is complex and multifaceted. The NHS Plan not only highlighted the impor-

tance of good communications but also recommended inter-professional collaboration (DoH, 2000). As two researchers who have encountered barriers to communication when conducting qualitative interviews we recognised the parallels between communications in the interviewing process and midwifery practice, and believe that sharing midwifery knowledge with other professions and vice versa can help to enhance and develop professional practice.

Interview or inter view?

The initial antenatal interview has been criticised for its task oriented approach which has been adopted by many midwives in order to complete what would appear to have become nothing more than a checklist within restricted time parameters (Methven, 1989). This may have resulted in midwives bombarding questions at women and expecting, and getting nothing more than, monosyllabic responses. The woman may then feel that she has not been listened to. When discussing interviewing within qualitative research Kvale (1996) states that 'an interview is literally an inter view, an interchange of views between two persons conversing about a common theme' (pp 44). Further to this Oakley (1981) emphasises the conversational nature of research interviews and that they should not be sterile, one way communication processes. Richens (1999) argues that in our quest for evidence-based practice we now turn to policies and protocols to inform our care, often forgetting that the woman herself is a valuable source of evidence.

Risk management

Our listening skills as midwives have been further undermined by the advent of risk management. Pregnancy and childbirth will always carry the possibility of unexpected and unwanted outcomes. This has led to high litigation rates in maternity units with management seeking ways to reduce this cost. The introduction of risk management as a systematic process to identify, analyse, evaluate and correct both potential and actual risk (DoH, 1994) has been utilised to this end. However, Aslam (1999) argues that

enhancement of client care should be the principal driving force of risk management not the reduction of litigation.

Unfortunately risk management has led to an increase in documentation which has reduced the time that the midwife can spend with women. It has also regimented midwifery practice with an increase of policies and protocols that can reduce the value of the woman's contribution to her individual plan of care.

Learning to listen

Both the midwife and the researcher need to acknowledge the importance of facilitating women to 'tell their own stories' when probing for information in order to plan care or collect data. Listening is a crucial element within the research interview and is also fundamental to the midwife-mother relationship (Kirkham, 1994). Midwives might like to consider the fact that when listening to the women they care for skills are utilised that are similar to those of the researcher. Developing an understanding of these skills can enhance the development of the midwife-mother relationship.

Again the initial antenatal interview provides a good example. The purpose of this interview is to gain knowledge of the mother's medical, social and psychological needs and to try and ensure that the foundation for a partnership in care is initiated. However, the midwife undertaking the interview may feel that it was the risk assessment component of the interview that was the dominating factor rather than the woman's individualised needs and anxieties. Likewise a researcher may have had a situation where they thought they were 'leading' the interview. This may result from an interviewee or interviewer feeling muted or silenced because of a perceived unequal partnership. These situations arise even though the researcher or midwife may not intend their voice to override that of the woman or interviewee; rather the purpose in both these scenarios is to facilitate the woman or interviewee to tell their story.

Hitchcock and Hughes (1995) state that when undertaking interviews the researcher must recognise the influence of a variety of social, cultural, institutional and linguistic

factors. The same principles apply to midwives who are striving to provide woman-centred care that takes into account the woman's social, psychological and cultural needs. This emphasises the fact that childbirth extends beyond medical considerations.

This is very pertinent at the present time when there is a growing body of knowledge and increasing awareness of issues surrounding domestic violence and sexual abuse (Price & Baird, 2001). It is only by developing ways that enable women to disclose and inform midwives of these issues that information can be gained to facilitate the women to share their experiences and difficulties. Perhaps by listening and tuning in to women and enabling them to tell their stories midwives can develop intuitive knowledge of the women they care for. This would help midwives to perceive the woman individually rather than 'just another pregnancy.'

Overbearing attitudes

Other barriers can arise to prevent women telling their stories, such as the midwife being seen by women as the holder of an authoritative knowledge base on childbirth. Battersby (2000) highlights this dilemma within the field of breastfeeding where women feel they are being coerced by midwives and health professionals into a feeding method contrary to their wishes. Within midwifery practice today the midwife no longer needs to be viewed as holding superior, authoritative knowledge but rather a partner in care provision whose knowledge base runs parallel with the woman's own knowledge base.

On reflection this devaluing and non acceptance of each others knowledge base might well stem from past styles of education, which has exposed midwives and women to didactic and authoritarian styles of teaching where the teacher was always right.

To enable partnerships to develop between women and midwives, and interviewers and interviewees the language used must be acceptable to both parties. If this is not undertaken then again barriers to communication can arise. Hitchcock and Hughes (1995) state that if the interviewer concentrates on the 'words, phrases and idioms,' (p169) within an interview then the interview becomes more meaningful. It enables the researcher to concentrate on the conversational aspects of interviewing and not on the technical issues which can so often mask the linguistic style of the interview (Mishler, 1991). We need to make sure that

the terminology used within midwife mother interactions facilitates the woman to take control of her own health by making her own choices about her health care.

Medicalisation of language

Miller (1973) states that language is '... by all odds the most subtle and powerful technique we have for controlling other people.' The language used by midwives is intrinsically linked with the use of medical definitions applied to midwifery care and this again is linked with the authoritative knowledge base of the profession. It can be argued that obstetricians have created a power base that has subsequently allowed them to control childbirth. Midwives have accepted and utilised the obstetricians' knowledge and language, and have therefore been granted power over childbearing women (Shirley & Mander, 1996) through the obstetricians.

Within research, a different vocabulary has emerged that can enable the researcher to hold power over the interviewee. It would seem sensible to all concerned to value each other's knowledge whilst at the same time developing a shared vocabulary that is comprehensible to all concerned. Within midwifery this will be even more important in the future when any letters written between health professionals regarding clients will be copied to them (DoH, 2000). Clearly midwives need to develop an awareness of the way in which they interact with their clients (Deery, 1999), as doing this inappropriately can leave long lasting impressions on the mothers and their family which can impinge on future childbearing and the wider health agenda (RCM, 2000).

In conclusion it can be seen that there are clear parallels between how the midwife and the researcher need to listen and use appropriate language within their respective fields. Communication is identified throughout the literature as being of paramount importance to the midwife/mother relationship.

Listening is an important skill that needs to be used effectively by midwives to facilitate women telling their stories; likewise the researcher needs to use the same skills to enable the interviewee to tell their story.

Language has been identified as a barrier to communications. Having a mutually acceptable language base for communications can help to reduce the power differentials between midwives, researchers and woman. Sharing knowledge from different disciplines has highlighted within this paper is just one of many ways in which communication awareness can be developed.

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